PROVIDENCE St. Peter Hospital

MEDICAL STAFF RULES AND REGULATIONS

PREAMBLE:

These Rules and Regulations are adopted pursuant to the Medical Staff Bylaws and supersede, as of the date of adoption, all previous rules and regulations.

Terms used herein shall have the same meaning given or applied to them as in the Medical Staff Bylaws, unless the context clearly indicates contrary.

These Rules and Regulations will be supplemented from time-to-time hereafter by policies, which may be approved by the Medical Executive Committee. Approved policies will be published and distributed to the Medical Staff at the discretion of the Medical Executive Committee

I. General Conduct of Care

A. Admissions

1. Except in an emergency, no patient shall be admitted to the hospital until provisional diagnosis or valid reasons for admission have been stated. In the case of an emergency, such statement shall be recorded as soon as possible.
2. At admission, the provider with the primary responsibility for authorizing patient treatment shall be the principle attending provider and will be so identified in all hospital data systems post discharge, unless a change in provider responsibility is specifically entered into the medical record by the provider.
3. The Emergency Center physician is responsible for a patient's care he/she deems necessary until such care is assumed by an attending provider.
4. A Medical Screening Exam must be performed by qualified medical personnel.
   a. In the Emergency Center and Family Birth Center (FBC) qualified personnel include:
      (1) Physicians
      (2) Certified Nurse Midwife (CNM)
      (3) Advanced Registered Nurse Practitioners (ARNP)
      (4) Physician Assistant (PA-Cs) with hospital privileges.

B. Discharges

1. Patients shall be discharged only on order of the attending provider.
2. Patients leaving the hospital against medical advice or without a discharge order require documentation of the circumstances preventing proper discharge in the medical record by the attending provider or nurse of record.

3. A Discharge-Against-Medical Advice from may be used for the required documentation and should be signed by the patient, patient's family or defined legal representative whenever possible.

C. Hospital Care

1. The principle attending provider of record or their delegate must evaluate their inpatient at least once per calendar day, except as defined otherwise within these Medical Staff Rules and Regulations.
2. For medically stable, long length of stay (LLOS) patients who remain hospitalized for an extended period of time because of logistical, legal or social reasons, daily rounding may not be medically necessary. For such patients, the principle attending provider of record or their delegate may determine the frequency of rounding which will not exceed seven (7) days (i.e. weekly rounding).
    a. Examples of medical stable (LLOS) patient include, but are not limited to patients with difficulty managing activities of daily living, requiring assistance with medication management, and/or some type of cognitive impairment.
    b. Utilization Management and Care Management will review the LLOS list and determine patient eligibility with the provider.
        1. The determination of patient eligibility will be documented within the Electronic Medical Record (EMR).
    c. The principle attending provider or their delegate will be available 24 hours per day, seven (7) days per week to respond to any acute issues that may arise.
    d. Rounding may be more frequent if medical issues arise.
    e. An interim transfer of care summary will be noted in the Electronic Medical Record (EMR). This summary will outline the hospital course and the on-going treatment plan of the patient.
3. Providers must designate appropriate coverage for their patients when not available.
4. The transfer of patient care from one provider to another requires agreement by both parties and must be documented in the medical records. On call coverage does not constitute transfer of care.
    a. The transferring provider is responsible for identifying and contacting the receiving provider prior to transfer of care responsibilities.
    b. The accepting provider will document acceptance in the medical record.
    c. In the event that the current attending provider cannot find an accepting providers, the Chief Medical Officer or Medical Staff President may provide assistance.
5. If a patient wishes to dismiss their current attending provider, it is the patient's responsibility to identify an accepting provider.
    a. The accepting provider will document acceptance in the Electronic Medical Record (EMR).
    b. In the event that the patient cannot find an accepting provider, the Chief Medical Officer or Medical Staff President may provide assistance.

6. Patient Restraints/Seclusion will be carried out in accordance with the Hospital's Restraints/Seclusion Policy.
7. The Medical Staff adopts and endorses the Washington State Medical Quality Assurance Commission Policy/Procedure "Self-Treatment or Treatment of Immediate Family Members."
8. All patients transferred between the inpatient psychiatric service and any inpatient services must have two distinct hospital accounts. Discharge and readmission of patients transferred between these services is necessary. Each hospital account involved in the transfer must have a history and physical and discharge summary.

D. Consultations

1. Consultation request required provider-to-provider communication.
2. The consultant or their designee is expected to complete consultations requested within 24 hours.

E. Orders

General Orders

1. With the exception of downtime episodes, all orders for hospital inpatients, observation patients, extended outpatient and patients in the emergency department shall be entered into the Electronic Medical Record (EMR).
2. Written orders are discouraged and must be printed legibly and include the provider's printed name and abbreviation of his/her degree trailing his/her signature.
   a. All written orders require a signature followed by provider's abbreviated degree and must include the date and time signed.
3. Orders to resume previous orders are not acceptable. Medication reconciliation and review of existing orders are required when patients are transferred out of the ICU and for post-operative transfers.
4. The Medical Executive Committee delegates clinical order set development, review, revision and approval to Providence Health & Services System (PH&S) and affiliate clinical expert collaboration groups, such as Clinical Program services, Institute focus groups and Clinical Decision teams. Clinical provider guidelines and standardized order sets are considered approved by the medical staff upon approval by designated review expert groups. When new/revised order sets have been approved, PH&S is responsible to communicate these updates to clinical caregivers. If the Medical Executive Committee has concerns or feedback regarding order sets, the Medical Executive Committee or designate can communicate with clinical expert collaboration leaders for consideration.
5. Medical Staff Members without Privileges may order outpatient infusion services within the scope of their licensure and specialty.

Verbal Orders

1. A verbal order is an order for treatment given while the provider is in the patient care area.
2. Verbal orders are limited to urgent or emergency situations in which immediate EMR entry is not possible without adversely impacting patient care.
3. Verbal orders will be confined to diagnostics or treatments required to care for the immediate needs of the patient.
4. Verbal orders must be entered into the EMR by the individual accepting the order who will read back the order to the provider for confirmation.
5. The ordering provider or designee shall sign a verbal order within timelines defined by regulatory standards.
6. Verbal orders for chemotherapy will not be accepted.

Telephone Orders

1. A telephone order is an order dictated over the telephone.
2. Orders dictated over the telephone must be entered into the EMR and include the name of the ordering provider and a signature from the authorized person transcribing the order. The authorized person transcribing the order will read back the order to the provider for confirmation.
3. The ordering provider or designee shall sign a telephone order within timelines defined by regulatory standards.

Acceptance of Verbal or Telephone Orders

1. The following are authorized to accept verbal orders or telephone orders within the scope of practice defined by their licensure, certification and/or job description:
    a. Registered nurses
    b. Licensed practical nurses
    c. Registered dieticians
    d. Respiratory therapists
    e. Pharmacists
    f. Laboratory staff (Lab assistant II, MLT and MT)
    g. Occupational therapists
    h. Speech language pathologists
    i. Radiologic technologists
    j. Ultrasound technologists
    k. Nuclear medicine technologists
    l. MRI technologists
    m. Cardiovascular technologists
    n. Physical therapists
    o. Electrophysiology technologists
    p. Health unit coordinators (for diet, activity and isolation orders ONLY)
    q. Master Social Work (MSW) (for orders related to discharge planning and admission status ONLY).

F. Patient Consents

1. Provider shall be responsible for obtaining a properly-executed informed consent in which the patient is provided with identification and explanation of the following:
    a. The nature and character of the proposed procedure(s) or treatment(s);
    b. The anticipated results of proposed procedure(s) or treatment(s);
    c. Recognized alternative forms of procedure(s) or treatment(s), including non-treatment of the patient;
    d. The risks and benefits of alternative to treatment and non-treatment;
    e. Anticipated benefit(s), recognized serious risk and possible complications.
2. Informed consent is required for procedures that are complex, invasive, and/or involve the risk of serious injury (e.g. blood transfusions, chemotherapy, surgery, anesthesia or analgesia, or non-routine diagnostic procedures such as myelograms, arteriograms, pyelograms, etc.).
3. Informed consent is the responsibility of the provider performing the procedure. It may be obtained by another provider ONLY if that provider is privileged to perform the procedure.

G. Documentation

General Principles

1. The principle attending provider is responsible for the completion of the patient's medical record, unless changes in provider responsibility are specifically entered into the medical record by the principle attending provider.
    a. When the principle attending provider is not clearly identified, the provider conducting the first definitive procedure, or the provider providing definitive treatment to the hospitalized patient for three days or greater will be the designated principle attending provider.
    b. Providers that feel this designation has been made in error may appeal to the Medical Staff President or their designee.
2. The Medical Staff President of designee has the authority to close an incomplete medical record/medical record delinquency.
3. The definition of an incomplete record is defined within the Medical Staff Delinquent Medical Records Policy.

History and Physicals (H&P's)

1. A complete history and physical exam include the following:
    a. History of present illness;
    b. Co-morbid conditions;
    c. Review of systems;
    d. Any pertinent social history;
    e. Current medications including doses;
    f. Medication allergies;
    g. Physical exam appropriate for the patient's condition;
    h. Assessment and plan.

2. A complete admission history and physical examination is required in the medical record within 24 hours of admission for inpatient services and prior to any procedure or surgery unless patient emergency.
    a. For obstetrical patients, a prenatal record within 30 days with an interval surgery, unless a delay note is required documentation for inpatient services and prior to any procedure or in providing anesthesia/epidural would be detrimental to the patient
    b. For obstetrical patients, a prenatal record documented within 30 days of admission or registration plus an interval note outlining any changes in condition or medications is required documentation for inpatient services and prior to any procedure or surgery, unless a delay in providing anesthesia/epidural would be detrimental to the patient.
3. A history and physical examination is valid for one year of encounters for ongoing outpatient infusion therapies including, but not limited to, blood transfusions or medication infusions.
4. A pre-procedural H&P may be legibly handwritten.
5. An H&P may be completed by a Level II Provider Extender with appropriate privileges.
6. A pre-procedural H&P may be accepted from a non-PSPH affiliated medical staff provider under the following circumstances:
    a. The PSPH-affiliated provider accepts the H&P as their own.
    b. The acceptance of a non-PSPH affiliated provider's H&P validates that all the requirements of a complete H&P are present in accordance with the requirements defined within Medical Staff Bylaws and Medical Staff Rules and Regulations.
    c. By acceptance of a non-affiliated provider's H&P, the PSPH-affiliated provider verifies the accuracy of the information contained in the H&P.
    d. The PSPH-affiliated provider appropriate updates the H&P in accordance with the requirements defined within Medical Staff Bylaws and Medical Staff Rules and Regulations.
7. In the case of a birth and death of a pre-viable fetus, the H&P will be comprised of a brief note that documents the circumstances of birth, gestational age, time of birth and time of death in the infant's chart. This document will also serve as the death note.

Pre-procedural H&P's

1. A complete H&P **is not required** for patients undergoing procedures that do not require moderate sedation or anesthesia services. However, documentation within the electronic medical record must include all of the following:
    a. Current medications and dosages
    b. Any known allergies
    c. Post procedural note
2. A complete H&P **is required** for patients undergoing procedures that require moderate sedation or anesthesia services. The required H&P components include all of the following:

a. Required Documentation for Moderate Sedation/MAC

(1) **HISTORY**
- (a) Indications/symptoms for procedure
- (b) Current medications and dosages
- (c) Any known allergies
- (d) Existing co-morbid conditions

(2) **PHYSICAL EXAMINATION**
- (a) Exam specific to the proposed procedure and any co-morbid conditions
- (b) Examination of the heart and lungs by auscultation
- (c) Airway assessment with Mallampati classification (This information may be located elsewhere in medical record.)

(3) **PRE-PROCEDURE NOTE**
- (a) Note on day of surgery that evaluates the patient's current status for surgery
- (b) Note can be written by a provider with appropriate clinical privileges
- (c) Note is not required when the H&P are written on the day of surgery

b. Required Documentation for General, Spinal or Epidural Anesthesia

(1) **HISTORY**
- (a) Indications/symptoms for procedure
- (b) Current medications and dosages
- (c) Any known allergies
- (d) Existing co-morbid conditions

(2) **PHYSICAL EXAMINATION**
- (a) Exam specific to the proposed procedure and any co-morbid conditions
- (b) Examination of the heart and lungs by auscultation
- (c) Physical examination of body system

(3) **IMPRESSION AND APPROACH TO TREATMENT**

(4) **PRE-PROCEDURE NOTE**
- (a) Note on day of surgery that evaluates the patient's current status for surgery
- (b) Note can be written by a provider with appropriate clinical privileges
- (c) Note is not required when the H&P are written on the day of surgery
- (d) For patients undergoing general or spinal anesthesia, the note must include an anesthesia history and risk assessment by an anesthesiologist
- (e) For patients who are scheduled only for an outpatient MRI under general anesthesia, the anesthesia history and risk assessment performed by an anesthesiologist can serve as the interval note, provided that no changes in the patient's condition have occurred. For patients who are scheduled only for an outpatient MRI under general anesthesia, and the history and physical evaluation from the referring provider is greater than 30 days, the anesthesia

history and risk assessment performed by an anesthesiologists can serve as the H&P examination.

3. A pre-procedural H&P and all necessary diagnostic studies shall be on the patient's chart and in the admission unit prior to the scheduled start of the case. Exceptions will be made when it can be demonstrated that delay would be detrimental to the patient. Insufficient pre-operative work-up may result in procedural delay or cancellation.
4. A pre-procedural H&P is valid for 30 days. When the medical H&P examination are completed within 30 days before admission or registration, an updated examination of the patient documenting any changes in the patient's condition must be completed and documented in the patient's medical records within 24 hours of admission or registration.
5. Any changes in the patient's condition must be documented by the provider in an interval note and entered into the patient's medical record with 24 hours of admission or registration, but prior to surgery or a procedure requiring anesthesia services.
6. When patients undergo pre-operative evaluation by another provider and the report is used by the surgeon as the pre-operative H&P, the report must be on the patient's chart prior to surgery.

Peri-operative Documentation

1. Operative reports shall be completed immediately following surgery by the surgeon performing the procedure or by the surgeon's Level II Provider Extender.
    a. The Level II Provider Extender may document the operative note provided that:
        (1) Operative reports shall be completed immediately following surgery by the surgeon performing the procedure or by the surgeon's Level II Provider Extender.
        (2) The surgeon performing the surgery co-signs with 48 hours.
        (3) A physician covering for the surgeon cannot co-sign.
2. Co-surgeons are required to dictate their own operative note or co-sign the dictating physician's note.
3. Required elements of an operative note include:
    a. Procedure description
    b. Post-operative diagnosis
    c. Surgeon's and assistant's names
    d. Findings
    e. Specimens removed
    f. Estimated blood loss (EBL)
4. Operative notes must be present on the chart prior to the patient being discharged from the PACU to the next level of care.

Discharge Summaries

1. Discharge summaries are required on all patients who have been in the hospital greater than 72 hours.
    a. All admitted obstetrical patients and newborn patients must have discharge summaries.
    b. For a patient stay less than 72 hours, a progress note, and patient disposition must be entered into the medical record.

2. Discharge summaries are required on all hospital deaths, and shall include a discharge note describing the reasons for admission, the hospital course, the events leading to and the case of the death of the patient.
3. A discharge summary must include the following:
    a. Admitting diagnoses
    b. Pertinent medical history
    c. Hospital course
    d. Complications
    e. Procedures, pertinent laboratory and x-ray findings
    f. Final diagnoses
    g. Disposition including any relevant information concerning physical limitations, diet, medications and return appointment
        (1) Medications listed on the discharge summary must match the medications list given to the patient at discharge.
        (2) Addendums to discharge summary are required if medications had to be changed after the summary was already completed.

H. General Call Responsibilities

1. Each medical staff department is responsible for developing and maintaining appropriate emergency call schedules for those specialties within its department. Emergency call participation by medical staff members shall be in accordance with applicable policies and procedures of the Medical Staff.
2. When a member of the Medical Staff reaches the age of 60 and/or other circumstances as approved by their departmental committee, they may request to be excluded from the community call schedule for their specialty.
    a. To initiate the process, the medical staff member must present his/her request in writing to the applicable departmental committee.
    b. The departmental committee must provide its recommendation to the Medical Executive Committee.
    c. Final approval is granted by the Medical Executive Committee.
3. If a provider, previously excluded from community call, elects to provide community call coverage for their practice group, that provider will attend any community call patient assigned to the group.
4. It is the provider's responsibility to coordinate their practice group(s) call schedule and provide the schedule to PSPH in a timely fashion. PSPH should promptly be made aware of changes in the call schedule.

II. Medical Staff Privileging – Appointment and Privileges

A. Departmental Committee Chair Report

1. The appropriate departmental committee chair or chair-appointed designee (hereafter referred to as "chair") will review and document the adequacy of an initial applicant's education, training, experience and current clinical competence for appointment and clinical privileges at PSPH.
2. If deficiencies are identified, the chair must document their rationale including reference to any unmet criteria for clinical privileges.

3. The chair may not defer consideration of any application except when identified inconsistencies exist or identified issues relating to clinical competency require additional follow-up.
4. If unable to submit a report, the chair will notify the Credentials Committee.
5. The chair's assessment will be added to the applicant's confidential file and will be forwarded to the Credentials Committee for review.

B. Credentials Committee Recommendation

1. Upon receipt of the departmental committee chair report, the Credentials Committee will review the applicant's complete application as soon as possible, but no later than its next regularly scheduled meeting.
2. The Credentials Committee will forward its findings and recommendations, along with supporting documentation, to the Medical Executive Committee.
3. Supporting documentation includes but is not limited to the application form, primary source verifications, privilege requests, documentation of education and clinical activity required in threshold criteria, peer references, the departmental committee chair's report, the Credentials Committee's recommendation; and any opposing views.
4. If the Credentials Committee recommends to defer action on the application, a recommendation for approval, modification or denial of staff appointment and clinical privileges must be provided within a reasonable period of time.
5. The Credentials Committee shall send the applicant written notice of any action to defer and provide an explanation for deferral.
6. The applicant may elect to withdraw their application and/or any of the requested clinical privileges at any time. All requests will become a part of the applicant's credential file.

C. Medical Executive Committee Recommendation

1. The Credentials Committee will forward a summary of the applicant's file, departmental chair report, and Credentials Committee recommendation to the Medical Executive Committee for review at the next committee meeting.
2. Upon completion of their review, the Medical Executive Committee will forward the Credentials Committee recommendation to the Community Ministry Board.

D. SW Community Mission Board Action

1. The SW Community Mission Board has the delegated authority and responsibility to represent the Board of Directors of Sisters of Providence in Washington in medical staff matters.
2. After reviewing the Medical Executive Committee and Credentials Committee recommendations, the SW Community Mission Board may adopt, reject in whole or in part, or refer the recommendation back to the Medical Executive Committee for further consideration.
3. If deferred for reconsideration, the authorized representative of the SW Community Mission Board must provide a written statement of the reasons for such referral and set a time limit for the Medical Executive Committee or Credentials Committee to make subsequent recommendations.
4. Medical Staff appointment and clinical privileges are granted by the Community Ministry Board. The SW Community Mission Board's authorized representative shall notify each applicant of the SW Community

Mission Board's final decision. A decision and notice of appointment includes:

a. The staff category to which the applicant is appointed
b. The clinical privileges the applicant may exercise
c. Any membership or privilege that is incomplete or not granted.
d. The effective from and through dates.
e. The reappointment date.

5. In the case of an adverse Credentials Committee or Medical Executive Committee recommendation, the SW Community Mission Board shall take final action in the matter as provided in the Medical Staff Bylaws.

E. Basis for Recommendations and Actions

All reports, including the SW Community Mission Board report, must include a recommendation or action taken, with specific reference to the completed application and any other documents considered. Any dissenting opinions during the process must be documented and supported by reasons and references, and transmitted with the majority report.

F. Joint Conference Committee

1. In cases where the SW Community Mission Board decision differs from the Medical Executive and Credentials Committees recommendations the matter will be submitted to a joint conference committee for review and recommendation before final decision by the SW Community Mission Board.
   a. The Joint Conference Committee is an ad-hoc committee
   b. Membership will include one member of the Credentials Committee, one Medical Staff Officer, a member of the Administration team and the SW Community Mission Board Chair or designee.

G. Time Periods for Processing

1. All individual and groups acting on an application for staff appointment must do so in a timely manner. Except in unusual circumstances, each application will be processed within the time periods below.
2. It is not an applicant's right to have an application processed within these precise periods. If the provisions of due process within the Medical Staff Bylaws are activated, the time requirements provided therein govern the continued processing an application.

Individual/Group	Time Period
Administrator (collect and summarize)	45 days
Departmental committee chair (to review and recommend)	30days
Credentials Committee (to reach recommendation)	45 days
Medical Executive Committee (to review and forward)	30 days
SW Community Mission Board (to render final decision)	30 days

III. Changes in Medical Staff Membership

A. Voluntary Resignation of Medical Staff Membership and/or Privileges

1. At any time, a medical staff member, allied health professional, Level II provider extender or Level I provider extender may voluntarily resign their membership and/or clinical privileges

2. A request for resignation must be received in writing to the Medical Staff Office within 30 days of intended action.
3. In the event a Medical Staff member provides shorter notice and does not arrange for call coverage, that fact will be reflected in any references provided thereafter.

B. Voluntary Request for Change in Medical Staff Membership

1. At any time, a medical staff member may voluntarily request a change in membership category to an alternate, appropriate category.
2. A request for change in membership category must be submitted to the Medical Staff Office.
3. A request will be processed in accordance with the medical staff's review and approval process. Adjudication will take approximately 45 days. Current community call responsibilities will remain in effect for all published call schedules.

C. Voluntary Request for Additional Clinical Privilege

1. At any time, a medical staff member may voluntarily request additional clinical privileges, provided that documentation is submitted in accordance with established threshold criteria.
2. A request for additional clinical privileges must be submitted to the Medical Staff Office.
3. A request will be processed in accordance with the medical staff's review and approval process. Approval for additional privileges will take approximately 45 days.

D. Involuntary Changes in Medical Staff Membership

1. Advancement to the Member with Privileges Medical Staff category may result in required participation in the emergency room call schedule for inpatient service at PSPH.
2. Unless otherwise stated, Members with Privileges who do not have clinical activity at PSPH during any reappointment period will automatically transition to Members without Privileges.

E. Leave of Absence

1. A leave of absence may be requested for medical reasons or for absence from profession or from the community.
2. Minimum timeframe for a leave of absence is 3 months; maximum is 12 months.
3. All duties and rights of membership, including clinical privileges and payment of dues, are waived during leave of absence.
4. A request for reinstatement from Leave of Absence must be submitted to the Medical Staff Office at least 30 days prior to intended reinstatement.
5. A summary of relevant activities during the leave of will be required and be reviewed by the Departmental Committee Chair, Credentials Committee, Medical Executive Committee and/or SW Community Ministry Board.
6. A medical release from the Medical Staff member's primary or specialty provider is required for a leave of absence related to illness.
    a. If accommodations are required, they must be included within the medical release.
7. A request for reinstatement will require the following:
    a. NPDB query
    b. Washington State licensure verification
    c. OIG/GSA query

d. Receipt of a current certificate of malpractice insurance
e. Receipt of a current DEA registration certificate, if applicable.

8. New reports identified within the NPDB query or state license verification will require the provider to complete and submit a reappointment application and privileges request (if applicable). In this circumstance, reinstatement will not occur until approval of a reappointment application by the community board.
9. If a Medical Staff Provider's reappointment date falls during his or her leave of absence, such reappointment must be accomplished within ninety (90) days after reinstatement.
10. If no clinical activity has occurred for 12 months, a training or mentoring plan will be required. Clinical activity is subject to review by the appropriate Departmental Committee Chair(s).

IV. Departmental Organization

A. General Principles

1. In accordance with the Medical Staff Bylaws, the Medical Staff is organized by departments.
   a. The departments of the Medical Staff include:
      (1) Emergency Medicine
      (2) Medicine
      (3) Perinatal Services
      (4) Primary Care
      (5) Surgery
   b. Duties of the chair are defined within the Medical Staff Bylaws and Medical Staff Departmental Committee Chair Position Description.
   c. Duties of departmental committee members:
      (1) Attend monthly departmental committee meetings.
      (2) Prepare for meetings by studying the published agendas in advance.
      (3) Communicate departmental committee decisions to department members.
      (4) Participate in professional practice evaluations, including review of initial appointment and reappointment files as requested by the chair.
      (5) Attend Medical Executive Committee in the absence of the departmental committee chair as requested by the chair.
      (6) Ex-officio members will be determined by individual departmental committees.
      (7) Attendance of ex-officio staff during confidential executive session discussions is at the discretion of the departmental committee chair.
2. Elections of committee members and departmental committee chair will occur on or about September of each year.
   a. When a vacancy occurs, the departmental committee chair may nominate another provider to the vacant position.
   b. After nomination and acceptance, the accepting provider's name will be forwarded to the Medical Executive Committee for acknowledgement.
3. In accordance with Medical Staff Bylaws, voting members of each department must be medical staff members.

4. Each department will receive direction from the Medical Executive Committee and conduct studies/projects/reviews as necessary to achieve the goal of continuous quality improvement as encompassed within the Quality Assessment Process at Providence St Peter Hospital protected under RCW 4.24 and 70.41.

B. Emergency Medicine Department

1. The Emergency Medicine Departmental Committee is comprised of nine members
    a. Departmental Committee Chair
    b. Olympia Emergency Services Executive Committee Representative
    c. Olympia Emergency Services Emergency Physician Member
    d. Internal Medicine Hospitalist Representative
    e. Surgery Physician Representative
    f. Olympia Emergency Services At-large ARNP or PA-C
    g. Emergency Center Nursing Director
    h. Emergency Center Nurse Clinical Manager
    i. Emergency Center Educator or other Staff Nurse.

2.Nursing representation is participatory and advisory.

3. Term of committee membership is two years.
    a. New members will be approved by ballot forwarded to Emergency Department medical staff members.
    b. At the end of two years, members will state their preference to continue as a member of the committee or vacate their position.
    c. Committee membership is limited to a total of three consecutive terms.
    d. Departing committee member will recommend his/her replacement.
    e. Term for the departmental committee chair is two years.
        (1) The chair will be nominated by committee members and approved by ballot forwarded to Emergency Department medical staff members.
        (2) The chair may serve up to a total of five consecutive two-year terms.

C. Medicine Department

General Principles

1. The Medicine Departmental Committee includes representatives from the following specialties:
    a. Allergy/Immunology/Dermatology/Endocrinology/Infectious Disease/Palliative Care
    b. Cardiology
    c. Diagnostic Radiology
    d. Gastroenterology
    e. Internal Medicine, Hospitalist (2)
    f. Internal Medicine, Non-hospitalist
    g. Medical Oncology
    h. Nephrology
    i. Neurology/Physical Medicine & Rehabilitation; Psychiatry
    j. Pulmonary Disease
    k. Term of committee membership is two years.
    l. New members will be approved by ballot forwarded to Medicine Department medical staff members.

m. At the end of two years, members will state their preference to continue as a member of the committee or vacate their position.
n. Departing committee member will recommend his/her replacement.
o. Committee membership is limited to a total of five consecutive terms.
p. Term for the departmental committee chair is two years.
    (1) The chair will be nominated by committee members and approved by ballot forwarded to Medicine Department medical staff members.
    (2) The chair may serve up to a total of five consecutive two-year terms, provided that their total committee membership does not exceed 10 years.
    (3) The future chair will be recommended by the departing committee chair from the current Medicine Departmental Committee membership.

Psychiatry

a. Voluntary Admission of Psychiatric Patients
    (1) A patient must have a diagnosis contained in the latest edition of the American Psychiatric Association Diagnostic and Statistical Manual
    (2) A patient must be appropriate for admission to the Psychiatric Unit in the opinion of the admitting provider.
b. Involuntary Admission of Psychiatric Patients
    (1) A patient may be admitted involuntarily after being detained by a designated crisis responder as defined by RCW 71.05 on the basis of being a danger to self or other or gravely disabled due to mental illness.
    (2) A patient may be detained involuntarily for up to six hours or until the next judicial day on the ward on an emergency basis when clinically indicated pending evaluation by the designated crisis responder.
    (3) Patients under age 18 and in need of immediate inpatient mental health treatment, but refusing to consent to a voluntary admission, may be held for up to 12 hours to enable a designated crisis responder to evaluate the child for possible involuntary commitment.
    (4) When a patient in the Emergency Center or on the Psychiatric Unit requires evaluation for involuntary detention and the patient's attending physician is unavailable, the designated crisis responder will be called directly by the Psychiatry Unit staff. The attending physician will be informed as soon as possible.
c. Psychiatrists employed by Providence are responsible for the coordination and provision of their patients' care within Psychiatric Services, as well as associated medical record documentation. In these circumstances, when the principle provider is not readily apparent, the designated principle provider shall default to the Medical Director of Psychiatric Services.

Critical Care

a. The ICU Medical Director and designee are charged with expeditious quality care as well as triage duties in the Critical Care Unit.
b. An ICU provider will review all critically ill patients on a daily basis.

c. The Medical Director or designee may provide consultation for any critically ill patients at their discretion.
d. Providers providing care for critically ill patients receiving mechanical ventilation for a period exceeding 24 hours must have the appropriate privilege to provide ongoing ventilator management or must obtain a consultation from an appropriate provider.

D. Perinatal Services Department

1. General Principles

a. The Perinatal Services Departmental Committee is comprised of the following related disciplines:
   (1) 3 OB Physicians
   (2) 2 Family Medicine Physicians with delivery privileges (one physician from PSPH Family Medicine Program Faculty)
   (3) 1 Pediatrician
   (4) 1 Anesthesiologist
   (5) 1 OB Hospitalist
   (6) 1 Pediatric Hospitalist
   (7) 1 Certified Nurse Midwife
   (8) 1 Nurse Director, Women's & Children's
   (9) 1 Nurse Educator, Family Birth Center & Pediatrics
   (10) 1 Staff Nurse, Family Birth Center
   (11) 1 Clinical Manager, Special Care Nursery
   (12) 1 Second or Third-year Family Practice Resident.
b. Term of committee membership is two years.
   (1) Departing committee member will recommend his/her replacement.
   (2) Term of committee membership may be extended by vote of departmental committee members from the members elected to serve.
   (3) Committee membership is limited to a total of five consecutive terms.
   (4) Term for the departmental committee chair is a minimum of one year.
      (a) The Chair must be a medical staff member, in good standing, with obstetrical privileges and with a minimum of one year of experience serving as a Perinatal Services Departmental Committee member.
      (b) The Chair may serve a maximum of 4 consecutive terms.
   (5) Candidate for chair and for committee membership positions will be approved by ballot forwarded to Perinatal Services Departmental Committee medical staff members.
   (6) The Perinatal Services Departmental Committee considers issues of credentialing and professional practice evaluations relative to obstetrics practice.
      (a) Issues of credentialing and professional practice evaluation relative to pediatrics and anesthesia will be referred to the respective departmental committees with comment from the Perinatal Services Committee.

(7) In addition to duties defined for departmental committee members, responsibilities of the Perinatal Services Departmental Committee shall be:
(a) Coordinate education for nursing, attending physicians and certified nurse midwives with emphasis on joint training opportunities.
(b) Foster an emphasis on patient safety and teamwork, including implementation of the Principles of Partnership.
(c) Review and resolve episodes of conflict between team members.

(8) Executive session professional practice evaluation.
(a) The entire Perinatal Services Departmental Committee will review and discuss executive session professional practice evaluation matters in strict confidentiality in order to preserve quality assurance protections.
(b) In accordance with the Medical Staff Bylaws, assignment of a quality variation is decided by a majority of the departmental committee's medical staff members.

2. General Obstetric Rules

a. All high-risk cesarean sections will be performed by a qualified team consisting of a surgeon, an assistant, an anesthesiologist, and attended by a pediatrician or family practitioner with special pediatric privileges for care of the infant.
(1) Low-risk scheduled repeat cesarean sections may be attended by a nurse who is qualified to provide newborn resuscitation excluding intubation and umbilical line placement.

b. The obstetrical care provider will determine responsibility for the baby at every birth and provide care as possible. The policy at Providence St. Peter Hospital and Puget Sound Blood Bank is Rh Immune Globulin (RhoGAM) is indicated for unsensitized Rh negative women at 28 weeks gestation; after abortion, ectopic pregnancy, amniocentesis, abdominal trauma; following delivery of an Rh positive infant. A mini-dose is indicated if gestation is less than 12 weeks. If RhoGAM has been given within the last three months, the Blood Bank should be notified since the passive antibody may still be detectable.

c. Providers who do not have obstetrical privileges and who admit a pregnant patient 20 weeks or later gestation must request an obstetrical consult.

3. General Pediatric Newborn Rules

a. The pediatrician or family medicine practitioner with high risk delivery privileges, other than the delivering physician, whose main responsibility is directed toward the care of the infant, will attend any birth at the request of the OB nurse or OB provider and all deliveries with high risk indications.

b. High risk indications include but are not limited to:
(1) Maternal Conditions:
(a) Abruptio placenta

(b) Placenta previa
(c) Intrapartum hemorrhage
(d) Pre-Eclampsia with magnesium sulfate
(e) Emergency cesarean section (0 or 30 minute C-section)
(f) Cord prolapse

(2) Fetal Conditions:
(a) Category 3 fetal heart rate tracing
(b) Premature delivery less than 36 0/7 weeks
(c) IUGR (intrauterine growth restriction)
(d) Meconium-stained amniotic fluid
(e) Multiple births
(f) Malpresentation with vaginal delivery
(g) Fetal anemia or isoimmunization
(h) Fetal hydrops
(i) Congenital anomaly anticipated to affect newborn well-being

c. When it is determined that a physician's attendance at birth is not required solely for care of the newborn, notification of pediatrician or family practitioner immediately after the birth is required for conditions to include:
(1) Current maternal perinatal substance abuse
(2) Isoimmunization
(3) Prolonged rupture of membranes greater than 24 hours
(4) Five minute Apgar less than 5

d. Elective delivery attendance (request for consultation attendance at low risk or repeat cesarean section) may be performed by the pediatrician or family practitioner primarily responsible for the infant, provided the physician is privileged for newborn resuscitation.

e. The OB physician will be asked to inform pediatricians of scheduled cesarean sections well in advance of the scheduled surgery.

f. Birth certificate completion is a combined effort between physicians, nursing personnel and Medical Records and will be accomplished at least ten days following the birth of the newborn. The delivering physician is responsible for completion of the obstetrical portion of the confidential information and the physician responsible for the care of the infant is responsible for completion of the confidential information regarding the newborn.

E. Primary Care Department

1. General Principles

a. The Primary Care Department represents Family Medicine, Pediatrics and relevant subspecialties.

b. The Primary Care Departmental Committee will be comprised of the following disciplines:
(1) 1 Community Pediatrician
(2) 1 Pediatric Hospitalist
(3) 3 Family Medicine Physicians
(4) 1 Office-based Family Medicine Physician
(5) 1 Palliative Care Provider

2. Term of committee membership is two years.

a. Members are encouraged to serve three successive terms (6 years) in order to ensure continuity.
b. The chair will be nominated by the Primary Care Departmental Committee and approved by ballot forwarded to Primary Care Department medical staff members.

3. Pediatrics
   a. Across all medical staff specialties, a pediatric patient is defined as a patient less than 18 years of age.
   b. Patient placement will be determined in the best interest of the patient.

F. Surgery Department

1. **General Principles**
   a. The Surgery Department is comprised of the following disciplines:
      (1) Anesthesiology
      (2) Gynecology
      (3) Interventional Radiology
      (4) Pathology
      (5) Radiation Oncology
      (6) Surgery
   b. The Surgery Departmental Committee will be comprised of the following disciplines:
      (1) 1 Anesthesiologist
      (2) 1 At-large Representative
      (3) 1 General Surgeon/Vascular Surgeon/Thoracic Surgeon
      (4) 1 Gynecologist
      (5) 1 Interventional Radiologist
      (6) 1 Pathologist
      (7) 2 Surgical Specialty Surgeons
   c. Term of committee membership is one year.
      (1) New members will be approved by ballot forwarded to Surgery Department medical staff members.
      (2) Members are encouraged to serve successive terms in order to ensure continuity.
      (3) There is no limitation on the number of consecutive terms a member can serve.
      (4) Term for the departmental committee chair is two years.
         (a) The chair will be nominated by committee members and approved by ballot forwarded to Surgery Department medical staff members.
         (b) There is no limitation on the number of consecutive terms a chair can serve.

2. **Community Call**
   a. Surgery Department medical staff members with privileges are assigned call responsibilities as defined in Medical Staff Bylaws
      (1) An exception may occur when community call coverage is provided by a separate contract between physician(s) and hospital administration.
      (2) Included within community call responsibilities for Surgery Department medical staff members with Core Gynecology

Privileges is the requirement to provide back-up coverage to OB hospitalists with Core Gynecology Privileges.

(a) The OB hospitalist with Core Gynecology Privileges has the responsibility of contacting the gynecologist on call.

(b) The gynecologist on call must provide assistance or accept primary care responsibility of the patient.

(3) In the event that a physician that has been excluded from community call is scheduled to provide community call coverage for his or her practice group, it is expected that the physician will attend any community call patient for which he or she is called.

(4) The general surgery call schedule will be published only with the name of the surgical hospitalist on call. Back-up will be provided by non-hospital general surgeons on an as-needed basis, as determined by the on call surgical hospitalist.

(5) There are no vascular surgeon community call requirements defined for the Providence St. Peter Hospital Medical Staff Organization due to no capability or capacity.

(6) Required urology community call coverage is a 1 in 7 day call rotation.

(7) Required ENT community call coverage is an approximate average of 1 in 5 days per month.

3. **Surgery Scheduling**

a. For 7:30 a.m. start cases, the anesthesiologist and surgeon will adhere to start time policy as outlined in Perioperative Services policy.

b. For “to follow” cases, the anesthesiologist and surgeon will be available at the posted time.

c. If the operating surgeon is more than 20 minutes late, the Medical Director of Perioperative Services, Director of Perioperative Services or designee may use his or her discretion to reschedule.

(1) The primary surgeon is responsible for procuring an assistant in all cases where one is required in order to assure the safety of the patient, to expedite the procedure, to assure adequate exposure or for whatever purpose such assistance is required for satisfactory completion of the surgical procedure.

4. Pre-operative Requirements

a. Are available in the Pre-operative Testing Policy.

5. Pathology Standards

a. Are available in the Pathology Standards Policy.

6. Trauma Multidisciplinary Committee

a. The Trauma Multidisciplinary Committee reports results which require consultation, advice or formal action to the Surgery Departmental Committee. The Surgery Departmental Committee is accountable to the Medical Executive Committee, which is a multi-specialty medical committee directing medical care at Providence St. Peter Hospital.

7. Perioperative Services Medical Director
    a. The Perioperative Services Medical Director is chartered to oversee daily operations in the Perioperative Services Department and is empowered to make and implement changes that improve efficiency and improve patient and physician satisfaction while maintaining high quality patient care. The Perioperative Services Medical Director may bring issues to the Surgery Departmental Committee for input and information.

V. Pharmacy and Therapeutics

A. The Providence St. Peter Hospital Medical Staff Organization delegates its authority for formulary decision-making to the centralized Providence Health & Services formulary process, led by a representative PH&S formulary committee of experts in medicine, pharmacy and nursing through the system and continuum of care.

1. The Providence St. Peter Hospital Medical Staff Organization will at all times be engaged in the formulary determination process, which ensures patients of Providence and its affiliates are provided with safe, high-quality and affordable medications through the continuum of care.

2. The Providence St. Peter Hospital Medical Staff Organization, through the Southwest Washington Region Pharmacy and Therapeutics Committee, will accept and adhere to the outcomes of the centralized Providence Health & Services formulary process.

3. An individual provider of the Providence St. Peter Hospital Medical Staff Organization may petition a formulary decision through the centralized Providence Health & Services formulary appeal process.
    a. The burden of proof of value (safety, efficacy, and cost) will be borne by on the individual(s) who advocates an alternative.
    b. Any appeal will be in coordination with a lead pharmacist who is a member of the Southwest Washington Region Pharmacy and Therapeutics Committee.

B. Adverse drug reaction will be reported through the PSPH Adverse Drug Reaction Reporting and Classification Program.

VI. Reviews/Revisions to Medical Staff Rules and Regulations

A. At a minimum, the Medical Executive Committee's review of these rules and regulations shall occur every three years.

B. Revisions to these rules and regulations are authorized by the Medical Executive Committee. Revisions shall become effective upon approval of the SW Community Ministry Board.

ADOPTED by the Medical Staff of St. Peter Hospital and approved by Executive Committee and Governing Board 10/27/1978.

REVISED by the Medical Staff of Providence St. Peter Hospital and approved by Medical Executive Committee and Community Ministry Board on 9/22/2016.

REVISED by the Medical Staff of Providence St. Peter Hospital and approved by Medical Executive Committee and Community Ministry Board on 8/22/2017.

REVISED by the Medical Staff of Providence St. Peter Hospital and approved by Medical Executive Committee and Community Ministry Board on 2/22/2018.

REVISED by the Medical Staff of Providence St. Peter Hospital and approved by Medical Executive Committee and Community Ministry Board on 5/24/2018.

REVISED by the Medical Staff of Providence St. Peter Hospital and approved by Medical Executive Committee and Community Ministry Board on 6/27/2019.

REVISED by the Medical Staff of Providence St. Peter Hospital and approved by Medical Executive Committee and Community Ministry Board on 7/25/2019.

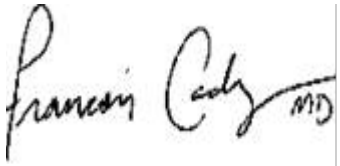
REVISED by the Medical Staff of Providence St. Peter Hospital and approved by Medical Executive Committee and Community Ministry Board on 10/24/2019.

REVISED by the Medical Staff of Providence St. Peter Hospital and approved by Medical Executive Committee and Community Ministry Board on 8/27/2020.

REVISED by the Medical Staff of Providence St. Peter Hospital and approved by Medical Executive Committee and Community Mission Board on 3/25/2021.

REVISED by the Medical Staff of Providence St. Peter Hospital and approved by Medical Executive Committee and Community Mission Board on 4/22/2021.

REVISED by the Medical Staff of Providence St. Peter Hospital and approved by Medical Executive Committee and Community Mission Board on 5/27/2021.



Francois M. Cady, MD, Medical Staff President

Jennifer Groberg, SW Community Ministry Board Chair